



Texas Department of Insurance

Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48

7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

SHANNON CLINIC
PO BOX 22000
SAN ANGELO TX 76902

Respondent Name

STATE OFFICE OF RISK MANAGEMENT

Carrier's Austin Representative Box

Box Number 45

MFDR Tracking Number

M4-12-1220-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary as stated on the Table of Disputed Services: "SORM is going off of Rule 129.5 Work Status Report paragraph (I) which states a doctor may bill. We believe Kay Millican FNP should be able to bill for this because she is the only medical professional to treat this patient. Kay Millican FNP works under Dr. Foxcroft M.D. Both have signed the DWC-73. SORM stated we could change and bill under Dr. Foxcroft. However we believe that is incorrect because he has NOT had contract with the patient. So, Kay Millican FNP should bill and sign the DWC-73. Possibly the working in Rule 129.5 Work Status Report paragraph (I) would read more appropriately as: A doctor or his/her licensed medical professional may bill for the DWC-73."

Amount in Dispute: \$15.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "In review of the dispute packet submitted by the requestor Shannon Clinic for date of service 6/22/2011, the Office reviewed the requestors billing and determined that the bill was denied in accordance with rule 129.5(a)(B)(2) which state the doctor shall file the Work Status Report"

Response Submitted by: State Office of Risk Management, PO Box 13777, Austin, TX 78711

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
June 22, 2011	CPT Code 99808	\$15.00	\$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.

Issues

1. Did the requestor submit the request for medical fee dispute resolution in accordance with 28 Texas Administrative Code §133.307 and is the requestor entitled to reimbursement?

Findings

1. Per 28 Texas Administrative Code §133.307(c)(2)(A), the provider shall complete the required sections of the request in the form and manner prescribed by the Division. The provider shall file the request with the MDR Section by any mail service or personal delivery. The request shall include: (A) a copy of all medical bill(s), in a paper billing format using an appropriate DWC approved paper billing format, as originally submitted to the carrier a copy of all medical bill(s) submitted to the carrier for reconsideration in accordance with §133.250 of this chapter (relating to Reconsideration for Payment of Medical Bills). Review of the documentation submitted show the bill was not submitted with the request for medical fee dispute resolution and the Division cannot confirm if the report was billed correctly. The Division concludes that the requestor has not met the requirements of §133.307(c)(2)(A); therefore, reimbursement is not recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is \$0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to \$0.00 reimbursement for the disputed services.

Authorized Signature

_____	_____	May 23, 2012
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.